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GUIDE FOR IMPROVING USE OF CESSATION SERVICES THROUGH TOBACCO CONTROL AND MEDICAID PARTNERSHIPS JULY 2009

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RATIONALE FOR TOBACCO CONTROL AND MEDICAID PARTNERSHIPS

Each state Medicaid program is both complex and unique making it difficult to offer generalized recommendations or advice for making changes. Rather, when changes are being considered for any Medicaid program, they need to be uniquely designed to fit into an individual state Medicaid system. Knowledge of the system and a patient timetable are needed to work through the complexities of each Medicaid system in order for any change to be successful.

Medicaid programs typically lack leadership and staff with tobacco cessation expertise. Or, if there is staff with tobacco expertise, their responsibilities may prevent them from devoting the necessary time to program development and oversight. Without that expertise, tobacco cessation benefits, which work best when they are designed to be as barrier-free as possible and regularly promoted, are often designed instead with the same cost controlling and access limiting features as typical benefits. Assumptions may be made that the demand for the benefit will be high, since smoking rates are high, and little effort is made to let anyone know the benefit exists. These steps make sense for benefits in a Medicaid program for which demand IS high. But, they do not help effectively increase access and use of tobacco cessation benefits and services.

The solution lies in the quality of the partnership between tobacco control programs, that have the tobacco cessation expertise, and state Medicaid programs that can facilitate the integration of a comprehensive benefit into their complex system.

DEFINITION OF PARTNERSHIPS

1. An active role for the state tobacco control/cessation program contributing technical support and expertise in the development of Medicaid covered services (e.g. participating in task forces, working groups, training programs).
2. An ongoing role for the state tobacco control/cessation program contributing expertise and technical support and assisting Medicaid staff to develop shared expertise for the sustainability of services.
3. Mutual shared capacity for and completion of data gathering and review for quality improvement purposes (e.g. collaboration of evaluation teams).
4. Shared quality improvement goals that could help lead to (or sustain) services that comply more closely with the PHS Clinical Practice Guidelines with reduced barriers to access.
5. Development of shared strategies for promotion of Medicaid services.
6. Contractual and/or funding relationships.

Definition of “ideal”, PHS compliant, reduced-barrier services:

- Coverage of all FDA approved medications.
- Coverage of multiple options for counseling/coaching (including quitlines)
- Access to several (2-3) courses of medication per year
- Access to multi-session counseling/coaching per year
- Low or no co-pay for services
- As free of restrictions as possible including eliminating: 1) requirements for prior authorization; 2) enrollment in programs to receive medications; 3) stepped care approach – failing on one medication before access to another; 4) limiting duration of pharmacotherapy and counseling and; 5) prescribing only one medication at a time (restricting use of combination medications).

ROLE OF TOBACCO CONTROL LEADERSHIP

The success of these more comprehensive Medicaid cessation benefit programs was a direct result of proactive leadership from the tobacco control programs. All six states agreed that without this leadership, the programs would be significantly less comprehensive and successful. Medicaid programs are responsible for administering and delivering a broad range of health services; a specific focus on tobacco is usually beyond their capacity. Personnel and job responsibilities can also change within the Medicaid programs. When the Medicaid tobacco champions leave or experience job changes, there can be a lapse in attention to tobacco issues.

Rather, it is the technical expertise and resources within the tobacco control programs that can remain constant, helping keep the program on track, addressing common barriers to benefit utilization and helping to design solutions. Further, the tobacco control programs may provide the primary leadership for gathering and interpreting outcome data and for helping to facilitate improvements. They all acknowledged that future and ongoing efforts from tobacco control programs, the need to “tend and maintain” partnerships, was necessary for the continued development of these Medicaid cessation benefit programs and for their ongoing success.

PARTNERSHIP DEVELOPMENT

Among the six states, Medicaid partnerships followed two types of development. In the states in which the tobacco control and Medicaid programs were essentially located in the same department of state government, a close partnership existed from the beginning, usually relying on preexisting working relationships and/or directives from the agency heads. These partnerships fostered collaboration, mutual goal setting, shared resources, and shared outcomes. In the states in which the tobacco control efforts were more separate from the Medicaid programs, the tobacco control programs tended to take the initiative for coordinating activities to improve outreach to Medicaid providers and recipients, designed systems to increase use of the benefit, and took the lead in developing Medicaid partnerships. Both models were successful but illustrate different pathways to developing partnerships.

An additional factor in partnership development is the political circumstances in each state. As the state political administrations change, Medicaid administration can change and priorities can change. Budget crises often affect Medicaid, and tobacco control programs often forcing the need to reprioritize. Sustaining partnerships through political, administrative, and budget changes can be challenging.

QUALITY IMPROVEMENT

The quality improvement process was dependent on the way tobacco control programs provided leadership and was shaped by the nature of the partnership. In the states with close partnerships, the working relationships themselves were often a significant source of quality improvement. The formal and informal working relationships provide multiple opportunities for sharing information and resources and helped to shape mutual decisions to undertake innovations and improvements in the program. In the states where the programs were more separate, process and outcome data was more often used to measure progress and reset goals. In all cases, as the tobacco control program became more expert in the complexities of the Medicaid system, they were able to provide increasing levels of the technical assistance and partnership necessary for effective quality improvement.

An important aspect of quality improvement that was reported in the case studies was the role of regular meetings and communication. Each state has a meeting schedule with the Medicaid programs. In some states (e.g.: Utah, New York) the tobacco control program has regular meetings of

their tobacco cessation staff that Medicaid representatives attend. These reporting and problem solving meetings help share information between programs and identify quality improvement steps. In other states, tobacco control staff attend regular Medicaid meetings (Oregon, Oklahoma, Wisconsin), report on tobacco outcomes, and discuss quality improvement. In Minnesota, this discussion is part of the regular Quitline Collaborative meetings.

QUITLINE DATA

All the states use their quitline data, broken down by insurance coverage, to illustrate the reach of tobacco control sponsored services and to make decisions about promotion and management. In Oregon and Utah, Medicaid reimburses for counseling and pharmacotherapy services through the quitline (and/or through participating health plans), so quitline data is an important measure of utilization. In Minnesota, most health plans provide quitline services to all members, including Medicaid recipients, so quitline data illustrates the reach of their plan covered services. In New York, Medicaid recipients can receive nicotine replacement therapy as a covered benefit through their health plan or they can receive it directly from the quitline. The quitline is heavily promoted making the quitline data in New York an important indicator of utilization. In Wisconsin and Oklahoma, the quitline is heavily promoted throughout the state together with promotion of the pharmacotherapy benefits available through Medicaid. Again, number of calls to the quitline is used as an indicator of reach into the whole population, including the Medicaid population.

PARTNERSHIPS TO OVERCOME BARRIERS TO UTILIZATION

Several common barriers to utilization were described; lack of awareness about the existence of the benefit, lack of clarity about the specifics of the benefit coverage, and lack of attention to outcomes. The partnerships between the Medicaid and tobacco control programs helped design solutions. For example, to address lack of awareness of the existence of the benefit among health care providers and Medicaid recipients, promotion efforts designed by the tobacco control programs included benefit information mailed with Medicaid eligibility cards (Oregon, Oklahoma, Utah) and benefit information disseminated via academic detailing (New York, Wisconsin). To address the lack of clarity about the details, tobacco control programs (New York, Wisconsin, Utah) developed fact sheets, hotlines, and other tools to accurately communicate these details and devised outreach strategies to make them available. To address the lack of attention to outcomes, tobacco control programs helped gather, analyze, and review program utilization data (Oregon, Oklahoma, Utah) subsequently prompting Medicaid programs to make changes in the quality of how they administer their benefits. In most of these examples, improvements came as a result of better coordination of existing resources between tobacco control programs and Medicaid programs and the ability of the tobacco control programs to both devise and recommend innovations. In all cases, leadership and support from tobacco control programs was essential.

MEDICAID “BENEFIT” VS. MEDICAID “PROGRAM”

All states described a benefit implementation process that requires an active, ongoing, and coordinated communication and education program. Unlike other benefits that are activated when patients seek help for illnesses, the tobacco cessation benefit requires a more proactive and coordinated approach to be effective. In this way, the “benefit” may be better understood as a “program service,” requiring more active planning, coordination, and evaluation. This distinction is especially important for improving utilization, since ongoing promotion and quality improvement is necessary to increase use of services.

MEDICAID AS PART OF A LARGER STATE NETWORK OF PUBLIC SERVICES

Medicaid programs are usually situated within a network of public state services. Improving benefits provided through Medicaid programs has the direct effect of improving services to Medicaid

recipients and an indirect “ripple” effect by influencing other public services provided through other state agencies. For example, benefits developed for the Oklahoma Medicaid program were subsequently extended to recipients of their low-income and small business insurance plan and influenced negotiations about benefits for state employees. In Oregon, where Medicaid benefits have been established for a decade, a collaboration is underway to merge systems between the Medicaid program and mental health program to permit mental health treatment specialists to be reimbursed for tobacco dependence treatment under the Medicaid rules, thus extended improved services for mental health consumers. Because of these relationships, the effort to develop partnerships between tobacco control and Medicaid programs can have a broader impact in a state, especially for people dependent on public services.

SUMMARY FOR TOBACCO CONTROL PROGRAMS

1. Be proactive. Proactive leadership is needed for developing better partnerships and to help with development, implementation and quality improvement of Medicaid benefits. The case studies show that an ongoing focus and technical support from tobacco control programs is needed for Medicaid programs to succeed. Working relationships between high level program managers and administrators are needed along with opportunities to provide information and resources to Medicaid programs. The case studies in this Report can help with developing partnership strategies.
2. Be knowledgeable about Medicaid. Medicaid programs rely on tobacco control programs for technical information and support about tobacco cessation and for help integrating tobacco cessation services into Medicaid programs. To be more effective, tobacco control programs need to be familiar enough with Medicaid programs to “speak the same language.” It will help to learn:
 - a. The basic outline of the federal/state Medicaid requirements.
 - b. The number of people enrolled in Medicaid in your state.
 - c. The mix of managed care and fee-for-service providers in your state.
 - e. A basic understanding of how managed health care works and about managed care quality improvement.
 - f. The cessation benefits and services currently provided through Medicaid and how they are reimbursed.
 - g. The meeting structure within Medicaid and where you can become involved.
 - h. How Medicaid quality improvement is handled.
 - i. The current political environment for the Medicaid program—where the priorities are.
 - j. What the needs are in your Medicaid program and which best practices from other states can help.
3. Approach changes in incremental steps. Every change to the Medicaid system is difficult and time consuming. Changes may have to be approved by multiple groups and, if there are budget implications, by the state legislature. Learn the process for making changes, help prioritize, and help support implementation. Be patient. Medicaid partnerships can be disrupted by changes in personnel, political changes in the administration, and changes in priorities.
4. Explore quitline/Medicaid partnerships. Quitlines are a primary source of tobacco cessation services in any state. Explore how quitline services and quitline data can be used to strengthen

Medicaid programs. Use some of the models in these case studies to help improve sharing of data and, when possible, costs.

5. Remain committed. The overall success of Medicaid and tobacco control partnerships relies on an ongoing working relationship. The partnership with Medicaid needs to be part of your tobacco control strategic plan with dedicated FTE and resources to help sustain the program.

ClearWay Minnesota collects and monitors data on pharmacy claims for Medicaid helpline clients and on NRT fulfillment through GlaxoSmithKline, the producer of branded nicotine patches, gum and lozenges, for other QUITPLAN Helpline, Center, and worksite clients.

OUTCOMES

Minnesota has designed its tobacco cessation efforts to provide benefits for all Minnesotans rather than targeting only selected populations. By creating a system that includes many partners and is capable of reaching nearly every smoker, the impact of the program across the entire population offers the best perspective, including the Medicaid population.

Data from the most recent Minnesota Adult Tobacco Survey¹⁰ show substantial improvements from 2003 through 2007:

- In 2007, more than half of adult Minnesotans who smoked in the past year made a quit attempt.
- Nearly 15% of Minnesota smokers used behavioral counseling to quit in 2007 compared to 3.6% in 2003.
 - 9.8% used one-on-one counseling from a doctor
 - 4.4% used a quit smoking clinic or class
 - 2.8% used online or web-based counseling
 - 2.2% used a helpline
 - 1.5% used other services
- Among smokers who tried to quit in 2007, 45.5% used stop smoking medications compared to 30.9% in 2003. Use of NRT increased from 26% in 2003 to 38.7% in 2007.
- Benefit coverage increased between 2003 and 2007. Among smokers who tried to quit in 2007, 57% received some financial assistance for the cost of medications compared to 46% in 2003.
- Among smokers who saw a health care provider in 2007, 86.5% were asked about their smoking compared to 72.9% in 2003.
- Overall smoking prevalence has declined from 22.1% in 1999 to 19.1% in 2003 to 17% in 2007.

LESSONS LEARNED

- Partnerships between the Minnesota Department of Health Tobacco Control Program, Clear Way Minnesota, and the health plans (including Medicaid) have created a comprehensive statewide system capable of delivering cessation services in multiple formats to all Minnesotans who smoke.
- The comprehensive nature of the programs has increased both access to more services and utilization of more services.
- Ongoing sharing of information and coordination is necessary to sustain the collaborative.

CONTRIBUTORS

Ann Wendling, MD, MPH
Director of Intervention Programs
ClearWay Minnesota

¹⁰ www.mnadulttobaccosurvey.org

NEW YORK TOBACCO CONTROL PROGRAM AND MEDICAID PARTNERSHIP PROJECT

PARTNERSHIP DEVELOPMENT

The New York Tobacco Control Program (NYTCP)¹¹ and the New York Medicaid¹² program are both housed in the New York State Department of Health (NYSDOH).¹³ The NYSDOH began an organized effort to address tobacco use with funding from the National Cancer Institute (NCI) for the American Stop Smoking Intervention Study (ASSIST) in 1991.¹⁴ A series of state level laws were passed between 1991 and 1998 restricting youth access to tobacco and increasing taxes on tobacco products resulting in an overall increase in price for tobacco users. In 1999, the NYSDOH initiated Medicaid coverage for prescription smoking cessation medications, which was later expanded to include over-the-counter cessation medications in 2000.

The NYTCP was established in 2000 with the Health Care Reform Act. The NYTCP is supported with funds from the Tobacco Master Settlement Agreement (MSA), State of New York excise taxes on tobacco, and other state funds.

Promoting cessation from tobacco use is one of the goals of the NYTCP comprehensive tobacco control strategic plan and has the following objectives:

1. To increase the number of health care provider organizations that have a system in place to screen all patients for tobacco use, provide brief advice to quit at every patient visit, and provide assistance to quit successfully.
2. To increase the percent of smokers who have quit successfully in the past 12 months. A “successful quit” is defined as quit now (smokefree for the past seven days) at six months after the quit date.
3. To increase the number of Medicaid recipients who access pharmacotherapy for smoking cessation through Medicaid.
4. To increase the percent of smokers with health insurance who report that their health plan provides coverage for tobacco dependence treatment.
5. To increase the percent of smokers who have heard of and who have called the New York State Smokers’ Quitline.

Five program activities are designed to promote cessation:

1. Support and technical assistance to health care organizations and providers to deliver guideline concordant care for treatment of tobacco use and dependence; and train providers to assess tobacco use status, offer brief cessation advice to tobacco users, and provide assistance to quit successfully.
2. Community education efforts to increase demand for and coverage of treatment for tobacco dependence directed at businesses, employers, employees, health insurance providers, and health care providers.
3. Paid and earned media campaigns to: a) motivate smokers to stop smoking, b) educate smokers about the health risks of smoking and the benefits of quitting, c) educate health care providers about the importance of treating tobacco use and dependence, and d) increase community awareness of the New York State Smokers’ Quit Line services available to help smokers stop smoking.

¹¹ http://www.health.state.ny.us/prevention/tobacco_control/

¹² http://www.health.state.ny.us/health_care/medicaid/

¹³ <http://www.health.state.ny.us/>

¹⁴ The American Stop Smoking Intervention Study for Cancer Prevention was a six year effort to reduce the smoking rate in 17 U.S. states. ASSIST was funded with approximately \$114 million from the early to mid 1990’s by the American Cancer Society and the National Cancer Institute. The goal of the project was to alter the social, cultural, environmental, and economic factors that promote smoking through four policy strategies: promoting smoke-free environments, countering tobacco advertising and promotion, limiting youth’s access to tobacco products; and raising excise taxes to increase the price of tobacco products.

4. Paid coverage for over-the-counter and prescription pharmacotherapy and behavioral counseling for tobacco use cessation for Medicaid recipients.
5. Provision of reactive and proactive telephone counseling, nicotine replacement therapy (NRT), information, services, and referrals by the New York State Smokers' Quitline to assist smokers and other tobacco users in quitting successfully.

ADDING MEDICAID SERVICES

In 2008, the Medicaid office contacted the NYTCP for recommendations for a new cessation counseling benefit for pregnant women. This collaboration resulted in a benefit that covers six counseling sessions per year by Medicaid eligible providers and is modeled after the federal Medicare benefit.¹⁵

The NYTCP added an activity into the workplans of the 19 Tobacco Cessation Centers to increase utilization of the new cessation counseling benefit for pregnant women. In doing so, the NYTCP helped create additional opportunities for partnership and enhanced relationship between the Medicaid program and the NYTCP.

As a next step for their partnership, discussions have been initiated regarding the possibility of expanding counseling benefits to pregnant smokers postpartum who relapse and reimbursing cessation counseling for youth and young adults aged 10 to 19 years old. NYTCP is currently drafting recommendations to provide the counseling benefit for all Medicaid recipients

THE ROLE OF TOBACCO CONTROL: IMPLEMENTATION

To implement the comprehensive plan, the NYTCP added an objective to build and maintain an effective tobacco control infrastructure. Included in the infrastructure are the nineteen Cessation Centers throughout New York state and the state supported Quitline.

Cessation Centers. The 19 Cessation Centers work with health-care organizations and providers to implement systems to screen patients for tobacco use and prompt providers to offer advice and assistance to quit. The Cessation Centers also serve as conduits for information and feedback about tobacco cessation coverage, including Medicaid benefits, for health care organizations and providers. As a two-way conduit of information, the Cessation Centers can help clarify the terms of Medicaid coverage for the different health plans and help with problem solving in specific cases. To help facilitate information exchange, the Medicaid office provided a direct phone number to answer benefit coverage questions at each cessation center.

As part of their annual work plan, the Cessation Centers have specific goals to increase utilization of Medicaid benefits, including the new benefit for pregnant women. These goals help focus outreach efforts and seek to increase the use of both the Medicaid pharmacotherapy benefit and counseling benefit

New York State Smokers' Quitline. The Quitline provides free nicotine patches, gum or lozenges for eligible NYS smokers. Trained quitline specialists offer coaching and encouragement for quit attempts, information about local stop smoking programs and informational taped messages to people who call or go online.

The basic quitline service for all residents of New York includes 2 weeks of NRT and 2 or 3 proactive coaching calls all at no cost. For Medicaid recipients and those who are uninsured, the Quitline provides enhanced services that include 4 additional weeks of NRT and up to 3 additional coaching calls.

¹⁵ The 2008 Medicare Physician Fee Database (MPFSDB) includes two CPT codes for Smoking and Tobacco Use Cessation Counseling. CPT Code 99406: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. CPT code 99407: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes. CMS' Smoking and Tobacco Use Cessation Counseling Billing Code Update available at: <http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf>

Access to over-the-counter NRT is also covered via the Medicaid pharmacy benefit. Medicaid recipients are required to have a fiscal order (prescription) for these products to be covered. Because NRT can be accessed through the quitline without a fiscal order, Medicaid recipients often take advantage of the quitline-sponsored NRT rather than get a fiscal order to be filled under the Medicaid pharmacy benefit. The NYTCP is in discussions with the Medicaid program about how to help Medicaid recipients access their pharmacy benefit more readily.

The full pharmacy benefit, counseling benefit for pregnant women and the Quitline are promoted through the Cessation Centers. The Quitline is also widely promoted through media advertising. By overlapping benefits available through the Medicaid program with those available through the Quitline, Medicaid recipients have multiple opportunities to access comprehensive services.

EVALUATION, QUALITY IMPROVEMENT AND OUTCOMES

The NYTCP has a goal of increasing utilization of the Medicaid pharmacy benefit and the pregnancy counseling benefit. The Cessation Centers contracted work plans include a specific quality improvement goal to increase utilization from one year to the next. The goals are based on a percent increase from the previous years' utilization, monitored through the Medicaid pharmacy and encounter claims data. The New York Medicaid program uses the same pharmacy plan for both fee-for-service and managed care covered recipients. Data on pharmacy utilization are reported from the Medicaid data warehouse annually. Data are broken down by county, forwarded to the Epidemiology Department and then provided to the Tobacco Control Program for review and planning for the Cessation Centers. As new goals are set, the Cessation Centers are responsible for providing outreach and technical support to the health care community in their respective counties. This includes providing information about the available benefit, responding to questions, and promoting use of the benefit. When Cessation Center staff members encounter questions that they cannot answer or if they need additional information for their academic detailing, they contact the Medicaid Office directly.

At the end of each contract year, all 19 Cessation Centers provide an end-of-the-year report including data on the past year's performance on key outcomes. The percent of actual increase in Medicaid utilization at the end of the contract year is compared to the planned level of utilization projected at the beginning of that year. Generally, the Cessation Centers have increased overall utilization within their catchment areas by approximately 5% for each of the last two years. Since the reimbursement for counseling pregnant women as a specific benefit was just implemented, the Cessation Centers will begin reporting utilization data for this benefit as well.

Within Medicaid, the Healthcare Effectiveness Data and Information Set (HEDIS)¹⁶ "Medical Assistance with Smoking Cessation (Ask, Advise, Assist)" measures are monitored biannually in the managed health plans using the Consumer Assessment of Healthcare Providers and Systems (CAHPS)¹⁷ surveys. Health plans that are below the state average on these (and other) HEDIS measures, are required to submit a quality improvement plan for increasing these scores. Technical support from the Medicaid office is provided, if needed, and progress on these quality improvement plans is monitored.

Overall, smoking prevalence in the Medicaid population has declined 19% from 2003 to 2006 (from 38.6% to 31.2%), similar to the 17% decline among the commercially insured population (from 17.7% to 14.7%).¹⁸

¹⁶ <http://www.ncqa.org>

¹⁷ <http://www.cahps.ahrq.gov>

¹⁸ http://www.health.state.ny.us/prevention/tobacco_control/docs/smoking_cessation_report_2006.pdf

LESSONS LEARNED

- The underutilization of Medicaid benefits is partly the result of both patients and providers not knowing what is covered and how to access benefits. The academic detailing done through the Cessation Centers provides a direct conduit of accurate information to Medicaid providers.
- Using pharmacy claims data to set goals for increasing Medicaid benefit utilization in the work-plans of the Cessation Centers provides the feedback necessary to develop targeted strategies that help increase utilization from year to year.
- As the Tobacco Control program continues to develop, there are increasing opportunities in its communication and meeting structure to involve more stakeholders and continue to build stronger partnerships to reach mutually beneficial goals, including with the Medicaid program.

CONTRIBUTORS:

Annie Beigel, BS, MFA
Manager of Cessation Programs
New York State Department of Health,
Tobacco Control Program

Jeffrey Willett, PhD
Director
New York State Department of Health,
Tobacco Control Program

Donna Haskin, Director
Program and Quality Initiatives Unit
New York State Department of Health
Office of Health Insurance Programs
Division of Financial Planning and Policy

Joyce A Novak, RN, MS
Consultant Nurse
Office of Health Insurance Programs
Division Of Quality and Evaluation
Bureau of Quality Measurement and Improvement

OKLAHOMA TOBACCO CONTROL AND MEDICAID “SOONERCARE” PARTNERSHIP

PARTNERSHIP DEVELOPMENT

Tobacco control in Oklahoma is jointly supported by the Tobacco Use Prevention (TUPS)¹⁹ in the Oklahoma State Department of Health (OSDH) and the Oklahoma Tobacco Settlement Endowment Trust (TSET),²⁰ founded in 2000. These two agencies work closely in designing, funding and implementing tobacco control programs and sharing information and resources.

The partnership between the TUPS, TSET and the Oklahoma Health Care Authority (OHCA),²¹ the state agency that administers the Medicaid (SoonerCare) program, began with regular meetings to identify opportunities for collaboration. Eventually the OSDH established a Federal Fund Development office that enabled staff to identify and prioritize needs within the public health agency and report to the OHCA. Multiple successful projects were collaboratively designed to increase access to care.

EARLY DISCUSSIONS

In 1999, TUPS established a comprehensive tobacco control program in Tulsa County, through the Tulsa City-County Health Department. One of the major emphases of the Tulsa program was to work with insurers to promote including tobacco dependence treatment as part of their core benefit package. Through this initiative, the Tulsa Cessation Systems Coordinator and the TUPS Cessation Systems Coordinator met with the Medicaid Medical Director several times to discuss implementing the benefit within Medicaid Managed Care. Through the Medical Director's efforts, several presentations were made to the medical directors of the health plans that served the Medicaid population. Although a great deal of interest was generated, most health plans indicated that they would have to first convince their health plan administrators. No breakthroughs occurred at that time.

In 2001, state agency heads from the OSDH, OHCA, and the Oklahoma Department of Mental Health and Substance Abuse Services forged productive working relationships under the Health Cabinet Secretary's leadership. This established a positive environment for TSET as the newest member of the Health Cabinet. The establishment of TSET, and its financial resources, created heightened interest among agency heads. The Executive Director was eager to build on existing relationships to help reach mutual goals. Then, as the tobacco control program grew, the OHCA medical director began advocating for an initiative within Medicaid to address tobacco use.

STRATEGIC PLAN AS CATALYST

These early discussions and working relationships synergistically converged at a strategic planning meeting in 2002. Thirty stakeholders attended, facilitated by a tobacco cessation expert from the Office on Smoking and Health at the Centers for Disease Control and Prevention. The Medicaid Medical Director participated in that meeting and subsequently made a commitment to pursue a tobacco cessation benefit. Through a series of monthly meetings between representatives from the Health Care Authority and the Health Department, a benefit initially for pregnant women was designed and approved by the Medical Advisory Board in 1999. In 2003, the benefit was expanded to all Medicaid recipients.

The partnerships developed to establish the SoonerCare cessation benefit expanded to impact health care benefits provided through Insure Oklahoma²² and those under consideration by the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB).

19 <http://www.health.state.ok.us/program/tobac/>

20 <http://www.ok.gov/tset/>

21 <http://www.ohca.state.ok.us/>

22 In April 2004, Senate Bill 1546 authorized the Oklahoma Health Care Authority to develop a program assisting adults, 19 to 64 years of age, who do not exceed 185% of the federal poverty level, with either (1) a portion of their private health plan premiums, or (2) the purchase of a state sponsored health plan operated under the state Medicaid program. The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC) Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an O-EPIC employer-sponsored health plan and work for an Oklahoma small business with 50 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work" <http://www.insureoklahoma.org>

MEDICAID SERVICES

The SoonerCare program is organized as a state-funded, fee-for-service program that contracts with primary care providers (PCP) and case managers to deliver services across the state. It is administered by the OHCA and offers varying health benefit packages.

As a first step, OCHA began covering all prescription and over-the-counter cessation products without prior authorization for the first 90 days. After 90 days of use within a 365-day period, prior authorization is required for additional 90 days coverage.

An important component of the Oklahoma Medicaid benefit is that cessation products do not count against either the 6 prescriptions per month limit or the 3 branded drugs per month limit. Therefore tobacco users do not have to choose between their cholesterol lowering medication and cessation products.

Within two years, Oklahoma Medicaid extended the smoking cessation program to include reimbursement for health care professionals. Current SoonerCare reimbursement rates are as follows:

- Smoking/Tobacco Cessation Counseling Sessions 3-10 minutes = \$12.89
- Smoking/Tobacco Cessation Counseling Sessions over 10 minutes = \$25.39

Each quit attempt may include up to four counseling sessions with a maximum of eight sessions in a twelve-month period. The Medicaid provider must implement the 5 A's as outlined in the PHS Clinical Practice Guideline to be eligible for reimbursement and document in the patient's medical record. Counseling visits can be billed by Medicaid eligible providers, excluding providers of behavioral health services.

All callers to the Oklahoma Tobacco Helpline are eligible to receive two week "starter" kits of free nicotine patches or gum if they enroll in the multiple call program. Callers are asked about their health insurance coverage and are educated about the associated cessation benefits. Therefore callers enrolled in Medicaid are encouraged to take advantage of the robust benefit offering in Oklahoma. Uninsured callers are eligible to receive up to eight weeks of free NRT if they remain enrolled in the multiple call program.

ROLE OF TOBACCO CONTROL

The working relationships among representatives from the Oklahoma State Department of Health, the Oklahoma Health Care Authority and the Oklahoma Tobacco Settlement Endowment Trust significantly facilitates any collaboration undertaken in the state. Each of these agencies readily shares expertise on a formal and informal basis. The TUPS and TSET teamed together to supply most of the initial expertise in the benefit development. Together, they assembled the necessary information on cessation and presented at meetings with the Oklahoma Health Care Authority as they worked through their decision making process. Eventually the Oklahoma State Department of Health presented a written proposal outlining the desired benefit package.

This teamwork continued through the expansion of the SoonerCare program and is ongoing through the quality improvement process. The tobacco control team assumes responsibility for sustaining the tobacco benefit within the Medicaid program, considering it "their job" to do the necessary legwork to make it easier for the Health Care Authority to act and also to keep tobacco a priority. Likewise, representatives from the Health Care Authority rely on the tobacco team to provide expertise, especially when new questions and issues arise.

BENEFIT IMPLEMENTATION

TSET and the OSDH jointly sponsor the Oklahoma Tobacco Helpline, launched in 2003. A colorful, hopeful flyer based on a similar flyer developed by the Oregon State Department of Health was mailed by the Health Care Authority to 150,000 beneficiaries in 2006 and 2007. The flyer announced

the benefit, encouraged talking to providers, and calling the Helpline for coaching.²³ The flyer prompted 2000 additional calls in 2006 and 1000 additional calls in 2007, raising the proportion of Medicaid-covered callers to the Helpline from 10% to 20%.

In 2008, the TSET worked with the Health Care Authority to design the provider reimbursement benefit. When the benefit was in place, the Health Care Authority sent a letter to providers announcing the new benefit and providing information on coverage and billing.

The TSET also has 27 grantees in their Communities of Excellence program.²⁴ Coordinators in these communities are responsible for the development of local comprehensive tobacco control programs. Part of each work plan is reaching local health care providers and promoting calls to the Helpline, including Medicaid recipients.

A collaborative CME project to promote the benefit and engage more health care providers, co-sponsored by TUPS and the Health Care Authority, was implemented in spring 2009. The project offered CME grand rounds in six communities featuring presentations from local doctors and pharmacists. Content included current information on tobacco cessation and how to access, code and bill for the Medicaid benefit. Participants were also educated about all Helpline services. Clinic office managers were also invited, to help improve their knowledge about billing codes and procedures.

EVALUATION AND QUALITY IMPROVEMENT

The tobacco team and the Health Care Authority collaborate on the benefit evaluation and quality improvement. The Health Care Authority reviews all medications with a prior authorization, including the smoking cessation medications, and reports annually to the Medicaid Utilization Review Board.

From July 2003 through June 2004, 732 clients received smoking cessation products through the Medicaid fee-for-service program. Varenicline (Chantix™) was still in development and is not included below.

Product (unit)	# of Claims	Total Units	Total Days	Units/Day	Total Cost	Total Clients	Per Diem
Zyban (ea)	209	12,686	6,783	1.87	\$24,129.78	165	\$3.56
Spray (ml)	28	1,325	591	2.24	\$4,900.24	15	\$8.29
Inhalers (cart)	271	27,734	4,571	6.07	\$23,073.65	162	\$5.05
Patches (ea)	749	16,774	16,846	1.00	\$64,307.65	540	\$3.82
Gum (ea)	15	2,340	267	8.76	\$924.87	12	\$3.46
Lozenges (ea)	25	2,532	281	9.01	\$1,282.96	9	\$4.56
Total	1,297	63,391	29,339	2.16	\$118,619.15	732*	\$4.04

Total Cost FY '04	\$118,619.15
<i>Total Cost FY '03</i>	\$18,142.80
Total Claims FY '04	1,297
<i>Total Claims FY '03</i>	187
Total Clients FY '04	732
<i>Total Clients FY '03</i>	129
Per Diem FY '04	\$4.04
<i>Per Diem FY '03</i>	\$3.80

*Oklahoma Health Care Authority FY 2004 , unduplicated numbers

²³ <http://www.ohca.state.ok.us/publications/pdf/lib/SFLENG%E2%80%93NOSMOK.pdf>

²⁴ Grantees have completed a rigorous strategic planning process and received grants to implement comprehensive tobacco control programs to reduce tobacco use throughout their communities. (http://www.ok.gov/tset/Programs/Tobacco_Use_Prevention_and_Cessation/index.html).

As a result of this review, the Drug Utilization Review Board was reassured that the benefit was not being overused and that an increase in use was desirable. In 2004, the preauthorization requirement was changed permitting access for the first 90 days without prior authorization.

A review of 2007 demonstrates the growth in the program, including the use of varenicline.

Product (unit)	# of Claim	Members	Total Cost
Zyban (ea)	240	179	\$16,571
Spray (ml)	9	5	\$1,552
Inhalers (cart)	343	234	\$49,459
Patches (ea)	4,372	3,207	\$361,992
Gum (ea)	302	208	\$18,674
Lozenges (ea)	174	114	\$9,869
Total	5,440	3,156*	\$458,118
Varenicline (Starter Pack)	4,884	4,374	\$483,451
Varenicline (1mg tab)	2,791	1,995	\$273,997
Total	7,675	4,750*	\$757,428

*Oklahoma Health Care Authority FY 2007, unduplicated numbers

Even with these improvements, utilization of the counseling benefit by health care providers lags behind. Discussions are underway about how to increase use of the counseling benefit. The CME project is one strategy. Also, the Health Care Authority is considering adding academic detailing in an effort to reach and educate each Medicaid provider.

The Tobacco Settlement Endowment Trust funds an independent evaluator from the University of Oklahoma College of Public Health, who directs the Oklahoma Tobacco Research Center. The independent evaluator helps analyze results from the Helpline, from the Behavioral Risk Factor Surveillance Survey (BRFSS), and from other programs, producing reliable and unbiased reports. These reports are shared among the tobacco team and the Health Care Authority. These data reports and the extensive network of collaborative relationships are used to help reduce barriers to tobacco cessation services and improve program success.

LESSONS LEARNED

- Medicaid programs need the support and expertise of tobacco control experts to help guide benefit development and quality improvement.
- Experts from outside the state can be instrumental in helping educate officials of the necessity to act on tobacco treatment and to provide information about how to proceed.
- Strong partnerships between agencies help move the tobacco control agenda along. Without such relationships there may be insufficient energy, interest and resources to sustain a necessary focus on tobacco control and treatment issues. Building these relationships takes time, but the investment can lead to a growing momentum for change.
- Establishing a comprehensive tobacco cessation benefit is not sufficient. Staff must also invest time and effort into promoting the benefit to both Medicaid recipients and providers.

CONTRIBUTORS

Sara (Sally) Carter, MSW, LCSW
Director of Statewide Initiatives
Tobacco Use Prevention Service
Oklahoma State Department of Health

Tracey Strader, MSW
Executive Director
Oklahoma Tobacco Settlement Endowment Trust

OREGON TOBACCO PREVENTION AND EDUCATION PROGRAM AND MEDICAID (OREGON HEALTH PLAN) PARTNERSHIP

PARTNERSHIP DEVELOPMENT

The Oregon Tobacco Prevention and Education Program (TPEP),²⁵ located in the Health Promotion and Chronic Disease Prevention Program of the Public Health Division of Department of Human Services (DHS),²⁶ was first funded in 1996 with state tobacco tax revenue. Prior to TPEP funding, the Health Promotion and Chronic Disease Prevention Program received CDC capacity building funding for a statewide tobacco control program and the American Heart Association received Robert Wood Johnson Smokeless States funding to establish the Tobacco-Free Coalition of Oregon (TOFCO). Included in the TOFCO work plan was a Health Systems Task Force. This task force convened representatives from managed care plans, from the Chronic Disease Prevention Program, from the Medicaid office, and from other agencies. The purpose of the Health Systems Task Force was to pursue strategies for integrating tobacco cessation as part of routine health care.

The Medicaid program, administered through the Oregon Division of Medical Assistance Programs (DMAP)²⁷ within DHS, is known as the Oregon Health Plan (see sidebar). Services through the Oregon Health Plan (OHP) are coordinated through a series of monthly meetings with the key health plan Medical Directors, health plan contractors, and quality assurance managers and coordinators.

After the OHP went into effect, a sub-committee of the Medical Directors group, Project: PREVENTION! was formed to help accelerate the rate of incorporation of preventive services and to develop system-wide prevention improvements for OHP members. With the emphasis on disease prevention, representatives from the Health Promotion and Chronic Disease Prevention Section within DHS played an important role on this subcommittee by providing expertise and technical support. As the tobacco control movement grew in Oregon and TPEP was funded, more momentum and resources to help address tobacco use within the OHP became available.

In 1998, tobacco cessation was included on the Oregon Health Plan list of prioritized services. With the expertise of TPEP and support from the Tobacco-Free Coalition of Oregon (TOFCO) the OHP

The Oregon Health Plan

The Division of Medical Assistance Programs (DMAP) is the Division within the state Department of Human Services (DHS) responsible for administering the Oregon Health Plan (OHP). The OHP provides health services for Oregon Medicaid and other low income Oregonians. The OHP was part of the 1989 Oregon health care reform initiative intended to make health care more available to the working poor while rationing benefits. The law passed in Oregon was not initially compatible with federal law, so a waiver was needed. The federal waiver was granted and the plan was approved on March 20, 1993 and went into effect in 1994.

The Basic Health Care Package (or covered services provided through the OHP), is determined by the Health Services Commission through a prioritized list process that is updated every two years. This list of health services is ranked by clinical effectiveness and value to society. The Legislature decides how much of the list to include in the Basic Health Care Package, and sets a state health care budget. The prioritized list emphasizes prevention and education according to the United States Public Health Service's Guide to Clinical Preventive Services. In general, services that help prevent illness are nearer to the beginning of the list than services that treat illness after it occurs.

²⁵ <http://www.oregon.gov/DHS/ph/tobacco/>

²⁶ <http://www.oregon.gov/DHS/ph/>

²⁷ <http://www.oregon.gov/DHS/healthplan/>

Medical Directors approved a new, comprehensive tobacco cessation benefit based on the Agency for Health Care Policy and Research Clinical Practice Guideline.²⁸ Through the Project: PREVENTION! Subcommittee and continuing collaboration with TPEP, TOFCO, DMAP and the health plans, a comprehensive program promoting tobacco cessation was designed, including a public awareness campaign for providers and OHP members, and promotion of the Oregon Tobacco Quit Line.

OREGON HEALTH PLAN (OHP) SERVICES

OHP services are delivered through a mix of managed health care and fee-for-service health care. Currently, 75-79% of OHP members receive care through OHP contracted managed care plans and the remainder receive care through fee-for-service providers.

Under the fee-for-service program, the State of Oregon Division of Medical Assistance Programs (DMAP) Rules describe the eligibility, covered services, billing requirements and limitations for tobacco cessation treatment. To be eligible for covered services, providers must generally follow the PHS Guidelines including a documented quit date for the patient. Reimbursable interventions include patient advice to quit, counseling, provision of cessation pharmacotherapy, and telephone counseling.

DMAP contracts with OHP managed care plans require the provision of tobacco cessation services that include education, counseling, and medications. Health plans are also responsible for ensuring that interventions delivered by participating providers incorporate the content of the 5 A's (Ask, Advise, Assess, Assist and Arrange) as described in the PHS Guideline. Providers are also encouraged to refer Medicaid recipients to the Oregon Tobacco Quit Line for services (see Quit Line Collaboration sidebar).

DMAP has rules for fee-for-service providers and contracts for managed health plans. The fee-for-service program makes no requirement for the linking of pharmacotherapy to counseling, however, some participating health plans make linking a requirement.

Fee-for-Service Rules

- When brief interventions are provided during a visit for other conditions, no additional billing is done.
- Licensed providers enrolled with DMAP can be reimbursed \$10.00 for each visit when intensive tobacco cessation treatment is provided. Treatments include individual, group, or telephone counseling.
- Reimbursement can be made for up to ten (10) sessions over a three-month period per member, including telephone counseling.
- All FDA approved medications are covered, including combination medications. Add s to medication (medications)
- There is a \$1.00 co-pay for generic NRT and \$3.00 for brand name.
- No limit on the number of weeks of NRT per year

Quit Line Collaboration

TPEP sponsors the Oregon Tobacco Quit Line (OTQL) and all callers are eligible for an initial counseling call. Enrollment in a full telephone counseling program is funded separately by participating health plans. The collaboration of the OHP health plans spurred an innovative approach to the purchase of quitline services. Many of the managed health plans participating with OHP collectively negotiated a contract with Free & Clear, the contracted service provider for the State of Oregon's Quit Line, thereby reducing the unit cost for each plan. Enrolling callers in the full Free & Clear counseling program became a seamless process for OHP members who call the OTQL. In this way, many OHP members receive a comprehensive program with a single phone call or a fax referral from their provider.

28 Fiore MC, et. al Smoking Cessation: Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. Agency for Health Care Policy and Research. April 1996.

Managed Care Contracts

Contracts covering managed care plans include preventive services based on the Oregon Health Services Commission (OHSC) prioritized list, and require that contractors also comply with OHP Tobacco Cessation standards and requirements. The specific treatment identified on the prioritized list is for medical therapy/brief counseling not to exceed 10 follow-up visits over 3 months and pharmacotherapy. Persons are eligible for this treatment if a documented quit date has been established. Each health plan sets up their own program and arrangement of resources. Some arrange for provision of NRT through their Quit Line contracts.

Examples of Health Plan Benefits

The following are examples of the benefits offered by two health plans that provide services to the Oregon Health Plan.

(1) Providence Health Plan

- Group programs 3 times per year; telephone counseling with Free & Clear—eligible to enroll one time per year. Individual counseling through a primary care provider (PCP).
- Nicotine patches and bupropion (Zyban™) provided through classes. Patches provided through Free & Clear. Varenicline (Chantix™), bupropion by prescription.
- Enrollment initiated by PCP or patient. Referral from PCP not required.

(2) CareOregon

- Individual counseling via provider throughout Oregon.
- Eligible for 10 counseling sessions per 12 months.
- Telephone counseling with Free & Clear. Eligible to enroll once per 12 months.
- Nicotine gum, patches, nasal spray, inhaler, Zyban™ provided without a small co-pay and without prior authorization. Prescription is needed. Eligible for two courses of treatment per year.
- Chantix™ is covered with prior authorization (PA) and enrollment in Free & Clear.
- Reimburses providers \$10.00 for providing assistance, i.e., help patient set a quit date, prescribe medications as appropriate, refer to Oregon Tobacco Quit Line or in-house cessation program, up to two times per 12 months.

IMPLEMENTATION: THE OREGON HEALTH PLAN (OHP) STATEWIDE TOBACCO CESSATION PROJECT

Implementation of the new benefit and services was approached as a coordinated statewide effort by the OHP health and OHP dental plans, helping to bring multiple partners together to share information, develop coordinated strategies and build a more integrated program. Additionally, the regular meeting structure provided a forum to feature best practices identified by one plan that could be readily shared with others, thereby accelerating the learning for all.

The OHP Statewide Tobacco Cessation Project work plan had three objectives:²⁹

1. To conduct a statewide coordinated information campaign to: a) improve both provider and member awareness of the covered benefit, b) demonstrate that the Oregon Tobacco Quit Line can be a good resource for tobacco cessation assistance, and c) show that getting help with quitting can increase success.
2. To increase the number of smokers covered by OHP who receive a level of service consistent with the recommendations in the PHS Clinical Practice Guideline or greater.
3. To decrease smoking prevalence among pregnant women and members with diabetes, asthma, COPD, or cardiovascular disease.

²⁹ The information in this section is summarized from a 2005 DMAP report: An Evaluation of Statewide Quality Improvement Activities by Oregon Health Plan Managed Care Organizations, 2003–2005

By 2003, 80% of the health plans in Oregon had formally adopted guidelines consistent with the US Public Health Service. Health plans were required to include tobacco cessation in their Performance Improvement Projects, and had incorporated smoking cessation measures into their QI programs. Beginning that year, health plans focused their cessation efforts on those most at risk: OHP members who were pregnant, had diabetes or had asthma.

Promotion

Each health plan promoted smoking cessation in ways unique to the organization and its membership. Promotional mailings were sent to members with their OHP eligibility cards, in January 2004 and again in January 2008. These mailings prompted large, time-limited increases in calls to the Oregon Tobacco Quit Line. Although Medicaid-specific call volume data are not available for 2004, the number of calls from OHP-enrolled tobacco users in January 2008 doubled compared to the same month in 2007, and call volumes from OHP members remained higher than usual through March. In January 2008, 155,000 English and 23,500 Spanish language flyers were included with the monthly eligibility mailing and in May an additional 2,500 in Russian and 3,500 in Vietnamese were sent.

EVALUATION AND QUALITY IMPROVEMENT

Each work plan objective had a data source to track quality improvement (QI). Reports from these data sources were reviewed at regular intervals (e.g. annually) to assess progress and to initiate quality improvement steps.

QI Objectives:

1. To improve provider and member awareness of the benefit and the help available. This objective is measured using three sets of data:
 - a. Medicaid Behavioral Risk Factors Surveillance System (BRFSS) survey
 - b. Oregon Tobacco Quit Line monthly reports
 - c. Provider survey-Physician Workforce Survey
2. To increase access to services. Baseline measures were established and health plans report their progress towards improvement goals through an annual Milestone Report. The Milestone Report had three parts:
 - a. A checklist of processes undertaken to ensure that the health plan incorporated smoking cessation into its QI process by reporting in four key areas: policy and planning, QI, communication, and clinical delivery systems.
 - b. An update of tobacco cessation activities and interventions since the prior year.
 - c. Request for internal data for members receiving pharmacotherapy and/or counseling services.
3. To decrease smoking among OHP members who are pregnant or who have chronic disease. The primary measure for the objective related to pregnancy is declining smoking rates among pregnant women based on data from Oregon birth certificates.

An additional data source, the Consumer Assessment of Health Plan Surveys (CAHPS)³⁰ is used to evaluate patient reported increases in services.

³⁰ <http://www.cahps.ahrq.gov>

OUTCOMES

By 2001, BRFSS data show that, compared to all Oregonians, more Medicaid recipients reported being asked (78% vs. 72%) and advised (64% vs. 58%) about tobacco use, and 52% vs. 38% reported receiving assistance to quit from their health care providers. In 2007, BRFSS data show that, while the sample size is small, this trend persists.

In 2005-2006, there was staff turnover in DMAP leaving the program without someone who was responsible for moving the activities along. The result was a temporary decline in the program illustrated by a nearly 60% decline in calls to the Quit Line among fee-for-service members in 2006 compared to 2005. Since then, new staff have taken on program responsibilities and participation rates as well as quality improvement activities are increasing.

In 2005, OMPRO (now Acumentra Health) completed "An Evaluation of Statewide Quality Improvement Activities by Oregon Health Plan Managed Care Organizations" outlined the quality improvement process for several indicators, including smoking cessation.³¹ The overall recommendations called for increasing the quality and consistency of the data collected and analyzed. DMAP has recently transitioned its data system to the Medicaid Management Information System (MMIS) which will help improve quality assurance data. DMAP is in the process of planning additional analysis coordinated internally among their research and pharmacy groups and with TPEP on the use of Quit Line data.

INTEGRATION

By 2008, the Tobacco Cessation Program was fully integrated into the OHP and no longer targeted in health plan performance improvement projects. Tobacco cessation is now a routine part of primary care, pregnancy care, and chronic disease management and representatives from DMAP are full partners in tobacco related conferences and state initiatives. Collaboration between DMAP and the TPEP program continues, especially in conjunction with the Memorandum of Agreement (MOA) for Free & Clear services. The ongoing collaboration and data sharing continues to prompt new quality improvement decisions. For example, a recent decision was made to eliminate an unnecessary barrier for OHP fee-for-service members seeking help through the OTQL. The original rules required that members get their medications through their primary care providers. A waiver was requested from the Centers for Medicaid and Medicare (CMS) to enable these members to get their medications through the OTQL in the same way that managed care members receive their medications. Implementation of this service improvement is expected in 2009. To further reduce barriers, there is also a plan to use a fax referral process to streamline access to NRT by fee-for-service members. In this system, health care providers would be able to write a prescription for NRT, fax to the OTQL, and have the prescription filled without requiring quitline counseling.

Additional integration steps are the inclusion of promotion and referral to the OTQL in the contract that provides Medicaid fee-for-service clients access to 24/7 Nurse Advice & Triage Telephone Services. Fee-for-service clients enrolled in the Disease and Medical Care Management program receive assessment, education and referral on tobacco cessation and the OTQL. Tobacco cessation is one of the clinical outcomes for disease management clients.

Finally, the TPEP and DHS leadership are also working closely together to determine how to integrate tobacco cessation in all DHS services, e.g.: the food stamp program. And, integration of tobacco cessation is being explored as part of the behavioral health and physical health integration efforts.

³¹ http://www.oregon.gov/DHS/healthplan/data_pubs/reports/qi0305.pdf.

LESSONS LEARNED

- Partnerships between state tobacco prevention programs and Medicaid can yield significant and lasting reductions in tobacco prevalence among the Medicaid population, which bears a disproportionate burden of tobacco dependence.
- As well as ensuring fulfillment of expectations for both parties, having the cessation-related financial relationship between the state tobacco prevention program and state Medicaid administration codified in a memorandum of agreement helps to ensure continuity of the relationship despite inevitable staff turnover.

CONTRIBUTORS:

Susan Good, RN
Disease Management/Prevention Coordinator
Division of Medical Assistance Programs
Oregon Department of Human Services

Laura Saddler, MPH, CHES
Self-Management Programs Manager
Health Promotion & Chronic Disease Prevention
Oregon Public Health Division
Oregon Department of Human Services

Sarah Bartelman, MPH
Quit Line Liaison Health Promotion & Chronic Disease Prevention
Oregon Public Health Division
Oregon Department of Human Services

UTAH TOBACCO PREVENTION AND CONTROL PROGRAM AND MEDICAID PARTNERSHIP

PARTNERSHIP DEVELOPMENT

Utah's Tobacco Prevention and Control Program (TPCP)³² and Utah's Medicaid Program³³ are both housed within the Utah Department of Health (UDOH).³⁴ The partnership between the Medicaid program, in the Division of Health Care Financing (DHCF), and the TPCP, in the Division of Community and Family Health Services, began in 2000 through a directive from the executive director of the UDOH. The executive director encouraged the DHCF and the TPCP to collaborate on a program to reduce smoking among pregnant women and to simultaneously help recoup some of the funding spent on Medicaid recipients due to their tobacco use. By proposing to use some of TPCP's Master Settlement Agreement (MSA) funds to support this Medicaid-based project, Utah was able to draw down additional federal Medicaid matching funds that, in turn, help increase the impact of their program. To make this happen, the TPCP contracts with the Medicaid program to implement a tobacco cessation education program for pregnant women covered under Medicaid. The combined TPCP MSA funding and state Medicaid and federal matching dollars support the program. The success of this initial program led to an expansion of services in 2003, adding cessation medications and Utah Tobacco Quit Line services for all Medicaid clients.

MEDICAID SERVICES

The goal of the cessation program and medication benefit is to reduce tobacco use among the Medicaid population, and specifically among Medicaid eligible pregnant women. To help accomplish this, two contracts were developed between the TPCP and DHCF.

Contract 1: The TPCP initiated the first contract with DHCF to reimburse Medicaid for the state portion of the Medicaid Health Program Representative's (HPRs) FTE. The HPR are responsible for proactively contacting newly enrolled or identified Medicaid pregnant women who report using tobacco. Each time a Medicaid eligible woman reports a pregnancy, a Division of Workforce Services eligibility worker asks if she has used tobacco in the last 30 days. The HPR then provide these women with information about available cessation services including the Utah Tobacco Quit Line and local health department programs. The HPR also collect and enter tobacco-related data into the Medicaid Managed Care Systems (MMCS) encounter database. Outreach staff follow-up with smoking pregnant clients every six weeks during the pregnancy and again after delivery. All of the Medicaid managed health plans have also established programs to identify new members who use tobacco and refer smokers to cessation programs.

Under the terms of this contract, TPCP reimburses the state portion of the cost of cessation medications for pregnant women (and other Medicaid clients), as determined by their health care provider. The Medicaid tobacco cessation pharmaceutical benefit covers all FDA approved cessation medications for Traditional Medicaid clients, including pregnant women. Some medications such as Zyban™/bupropion and Chantix™ are covered for Non-Traditional and Primary Care Network clients. The Medicaid pharmacy benefit is carved out of managed care contracts and is structured as a direct fee-for-service point of sale.

As part of the initial program development process for this contract, DHCF queried all 12 of Utah's local health departments about participating as a provider of cessation services for Medicaid eligible pregnant women. If interested, providers were asked to complete a form establishing them as a Medicaid provider. The agencies already enrolled as providers of Medicaid services and community

³² <http://www.tobaccofreeutah.org/>

³³ <http://health.utah.gov/medicaid/>

³⁴ <http://hlunix.ex.state.ut.us/>

health centers were exempted from this request. Following the query, three smoking cessation programs located at the Salt Lake Valley Health Department, the Southwest Utah District Health Department and the Tooele County Health Department, were approved and began delivering services in 2001. Self-help guides coupled with telephone follow-up were provided for women lacking access to one of the local programs. Eligible programs were required to provide specific services including:

- Information about the effects of smoking on the mother and the fetus/infant and the benefits of quitting.
- Focus on changes in lifestyle, social issues, emotional issues such as guilt regarding smoking, and post-cessation weight gain.
- Collaboration with the woman's primary care provider.
- Referral of women with additional substance abuse issues to appropriate mental health or substance abuse treatment providers.
- Process to continue to support and encourage women to remain smoke-free.
- Strategies to prevent relapse after delivery.
- In the event that a woman was unable to quit smoking on her own or with behavioral treatments alone, discussion of medications such as nicotine replacement therapy (NRT) and bupropion. Only after the potential risks/benefits associated with pharmacotherapies were discussed could medications be approved and ordered by a physician.

Optional follow-up home visits and telephone contact were also offered through a newly created Medicaid home visitation program.

Following 2001, provider and service delivery expanded to incorporate all 12 of the district health departments throughout the state including many of the rural local health department sites.

Contract 2: The second contract was initiated by the Medicaid program with TPCP. The contract: 1) funds services for all Medicaid recipients through the Utah Tobacco Quit Line, and 2) helps fund marketing campaigns to increase quitline service utilization. The TPCP contracts with Free & Clear Inc. for quitline services. Medicaid clients who call the quitline are eligible, at no cost, for the multiple-call intensive coaching program and up to eight weeks of nicotine replacement therapy (patch or gum), when not contraindicated. Free & Clear Inc. identifies Medicaid callers on a monthly invoice to the TPCP, which is forwarded to the DHCF. The federal match portion of the cost for services for these callers is then reimbursed by the Medicaid program.

Federal Matching

The Utah Medicaid program has been able to leverage additional federal matching funds on both professional rates and service rates through their contracts with TPCP. Funds for the Medicaid professional staff supported through the TPCP contract are eligible for the higher professional match rate (25% state/75% federal), and other staff at a 50/50 match. Individual classes, materials and pharmaceuticals are eligible for the current federal services match (22.36% state/77.67% federal).

The Medicaid program also helps support a percent of the cost of TPCP marketing campaigns based on the proportion of the Medicaid population reached by the campaigns. In addition, the tobacco cessation services provided to Medicaid clients through the Utah Tobacco Quit Line also draw down a federal match.

ROLE OF TOBACCO CONTROL

The TPCP provided leadership in designing the Medicaid-based cessation program by contributing cessation expertise and providing information and data to help guide the overall development. The TPCP provided much of the initial training and continues to provide training to Medicaid staff as

needed and contributes to the evaluation process. Medicaid and TPCP staff members meet monthly and continue to collaborate on the program.

IMPLEMENTATION AND PROMOTION

Approximately 80% of Medicaid cessation services in Utah are provided through managed care health plans. The remaining 20% are provided through fee-for-service providers, primarily in rural areas of the state. Implementation of the cessation benefit resulted from multiple outreach efforts.

Promotional materials were developed by the Medicaid program and disseminated to their contracting health plans and provider networks. The Medicaid program drafted articles for various publications, such as the Medicaid Information Bulletin (MIB), and sent information letters to local health departments. To ensure high quality promotional materials, Medicaid staff coordinated with TCPC's The TRUTH marketing campaign. In 2007, Medicaid informed clients who resided in areas with high tobacco use rates about its tobacco cessation benefits. High risk areas were identified through the Behavioral Risk Factor Surveillance System (BRFSS) Small Area Data Report.

Training

Staff at the local health departments provide a 5 A's and fax referral training program for healthcare providers using TPCP-developed TRUTH Network materials. Included in the outreach is information about the tobacco cessation resources available to Medicaid recipients and a tool for providers called the "Tobacco Cessation Benefits for Medicaid and Primary Care Network Patients" matrix. This matrix lists the categories of the Utah Medicaid program (i.e. Traditional, Non-Traditional and Primary Care Network) and which tobacco cessation medications are covered for each category.³⁵

In order to help inform providers, programs and agencies of new services or changes to existing programs or services, the Medicaid staff, funded through TPCP, provide ongoing training, technical assistance and support. This technical assistance is provided during site visits, teleconferences or through the use of state or locally operated websites. Medicaid also supports annual statewide on-site training for all providers that includes information about the tobacco cessation program.

EVALUATION AND QUALITY IMPROVEMENT

The TPCP and Medicaid collaborate on evaluation of the program and quality improvement. In the beginning of the partnership, the Medicaid Health Program Representatives (HPR) used a paper system to track and follow-up with Medicaid clients. TPCP and Medicaid staff worked together to develop a database to improve tracking of the expanded outreach efforts for pregnant women. The new system has the following components:

- All data are entered electronically at the time of service, eliminating the need for paper records and additional data entry staff.
- Use of the electronic system to provide automatic reminders for the HPRs to ask pregnant women about tobacco use and the timing of follow-ups.
- Scripts patterned after the Public Health Service's Clinical Practice Guideline on Treating Tobacco use and Dependence. For example, in addition to collecting data, the follow-up calls now incorporate motivational interview wording based on the "5 A's" (Ask, Assess, Advise, Assist, Arrange) to encourage tobacco cessation.
- Reports generated at regular intervals and sent to Medicaid administrators and TPCP.

The TPCP and Medicaid intend to increase utilization of the prenatal and postnatal counseling benefit and the smoking cessation pharmacy benefit. At the end of each fiscal year, TPCP and Medicaid staff review counseling and medication claims data and set new quality improvement goals for

³⁵ <http://www.tobaccofreeutah.org/medpcnbenefits.pdf> pregnant Medicaid eligible women who reported using tobacco.

the next year. These goals, along with specific activities to achieve the goals, are included in the Medicaid work plan that is shared with everyone involved in the Medicaid/TPCP partnership.

The Utah health plans that provide Medicaid services, Molina Select Access and Healthy U, track client success in tobacco cessation programs through their quality improvement committees.

Evaluation

Multiple data sources and monthly reports provide evaluation and quality improvement data for the Utah program:

- **Behavioral Risk Factor Surveillance System (BRFSS)**
From 1997 to 2000, Utah tracked smoking rates among Medicaid recipients through the BRFSS. The combined rate for 1997 to 2000 was 31.5%. From 2001 to 2007, healthcare-related questions were asked on a separate Utah household survey (Utah Healthcare Access Survey - UHAS) that did not measure current smoking. As a result, smoking rates for Medicaid recipients are not available for those years. In 2008, Utah conducted a pilot study that combined BRFSS questions and questions from UHAS. This study found a smoking prevalence for Medicaid clients of 23.9%. Starting in 2009, Medicaid smoking prevalence will be tracked annually through the combined BRFSS/UHAS.
- **Birth Certificate Data**
Birth certificate data are used to populate a Targeted Case Management (TCM) report used by local health department staff who conduct targeted case management visits to the homes of Medicaid newborns. Utah birth certificate data are available through the UDOH's online Indicator Based Information System for Public Health (IBIS-PH).³⁶
- **Utah Tobacco Quit Line Medicaid Invoice**
Monthly report used to track the number of Medicaid clients who used the Quit Line. It is also used to verify eligibility for the service and ensure that Medicaid reimbursement is only paid for eligible clients. Approximately 70 Medicaid eligible clients use the Quit Line for cessation help each month, with a spike of over 100 Medicaid clients calling the Quit Line during the month of January 2009.
- **Medicaid Pregnant Women Survey Reports (from MMCS)**
Monthly report that is used to direct improvements, gauge efforts and track trends over time. The report includes: the number of Medicaid eligible women reporting pregnancy, the number of Medicaid eligible pregnant women who took a tobacco use survey or refused the survey, the number of Medicaid eligible pregnant women who are reporting tobacco use, and survey totals listed for each participating agency.
- **Medicaid Pregnant Women Contact Summary (from MMCS)**
Monthly report that shows the contacts that the Health Program Representatives (HPRs) make with the Medicaid eligible pregnant women that have been identified as using tobacco through the tobacco use survey. The Medicaid Pregnant Women Contact Summary Report includes the number of smokers, the number of smokers that want to quit, the number of smokers who have set a quit date, the number of smokers who have reduced their tobacco use or quit, the number of follow-ups the pregnant women have received, and the number of cessation services referred to and used. This report is reviewed monthly to track the assistance that Medicaid eligible pregnant women receive and quit/reduction rates.
- **The Data Warehouse**
Medicaid database that serves as a "gatekeeper" to access multiple databases that assist in determining program utilization such as the number of pregnant women receiving prenatal counseling and tobacco cessation prescription claims.

³⁶ <http://ibis.health.utah.gov/query/selection/birth/BirthSelection.html>. Note: The rate declined from 15.5% in 2002 to 13.7% in 2007; data limitation: the target population (pregnant women on Medicaid) changes from year to year; data are subject to recall bias.

New Developments

A recent quality improvement development is the ability to access and combine data from multiple Medicaid data sources. Over the past several months, Medicaid has worked with IT staff to define, design, and implement new reports based on data from MMIS, MMCS, the Data Warehouse, Vital Records and others. The result is a single, condensed report, rather than multiple reports that need to be combined, with fewer errors. An example of an improved report is a standardized “Medicaid Tobacco Cessation Medication Report” under development. This report will show total monthly pharmacy claims data for bupropion (Zyban™), varenicline (Chantix™), and nicotine replacement therapies (NRTs) used both by Medicaid pregnant and non-pregnant recipients. The Tobacco Cessation Medication Report is generated by MMCS, but the claims data is pulled from the Data Warehouse.

New promotional strategies include mailing a Utah Tobacco Quit Line/Utah QuitNet flyer with the April 2009 Medicaid eligibility cards³⁷ and including referrals to quitting services on Child Health Evaluation and Care letters sent to the parents of children on Medicaid. Although it is too soon to evaluate outcomes, the April 2009 Quit Line monthly report shows an increase in calls from Medicaid clients, with 18% reporting that they called because of a brochure/flier.

LESSONS LEARNED

- Time, management support, and patience are necessary components of this collaboration.
- Good communication and shared data between Medicaid, TPCP, Finance, and management staff is critical; the rewards and benefits are many. Services are made available to high-risk populations, systems change is enabled, new partnerships are established between State agencies, local health departments are able to expand their services, use of state tobacco funds is maximized, and perhaps most importantly, there is great potential for lowering tobacco use rates, saving lives, and reducing Medicaid and other State funds spent on low birth weight infants.
- Underutilization of services is a continuing challenge, which speaks directly to the need for an ongoing targeted marketing campaign.

CONTRIBUTORS

Marci Nelson
Health Program Specialist
Tobacco Prevention and Control Program
Utah Department of Health
Phone: (801) 538-7002
marcinselton@utah.gov

Russ Labrum
Health Program Manager
Division of Healthcare Financing
Utah Department of Health
Phone: (801) 538-6206
russlabrum@utah.gov

³⁷ “Do You Want to Quit?” available at <http://www.tcln.org/tcln/cessation/medicare>

WISCONSIN

TOBACCO PREVENTION AND CONTROL PROGRAM & MEDICAID PARTNERSHIP

PARTNERSHIP DEVELOPMENT

Wisconsin was one of the 17 states that participated in the American Stop Smoking Intervention Study (ASSIST) from 1991-1999.³⁸ The current Wisconsin Tobacco Prevention and Control Program (WTPCP)³⁹ was funded in 2000 and, in turn, contracted with the University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI)⁴⁰ to lead Wisconsin's tobacco cessation initiatives.

Both the Quit Line and UW-CTRI Outreach programs are funded by the WTPCP. The Medicaid program first approved a stop smoking benefit in 1996, during the time of the ASSIST funding. With the subsequent funding of the WTPCP and UW-CTRI, new expertise was added and new opportunities for partnerships between the WTPCP, through UW-CTRI, and the Medicaid program were created.

An early step by UW-CTRI was to engage the Medicaid program in reviewing the tobacco cessation benefit. At that time, the benefit required that recipients be enrolled in tobacco cessation counseling in order to be eligible for their pharmacy benefit. By then, the best practice of "unbundling" pharmacy counseling and pharmacy benefits had emerged. Through their early collaboration, this barrier was eliminated and further opportunities for partnership were developed.

University of Wisconsin, Center for Tobacco Research and Intervention

UW-CTRI was founded in 1992 and has become a national leader on taking results from tobacco research and applying it to improve tobacco treatment provided by healthcare providers to patients who want to quit smoking. UW-CTRI provides training and technical assistance to thousands of Wisconsin clinicians through its outreach program and the Wisconsin Tobacco Quit Line, which has helped almost 150,000 tobacco users since 2001.

MEDICAID SERVICES

The Wisconsin Medicaid benefit covers all FDA approved stop smoking prescription medications and office visits for the purpose of tobacco dependence treatment. Over-the-counter nicotine replacement therapy (NRT), with the exception of the nicotine lozenge, is also covered, but requires a prescription.

Approximately 70% of Wisconsin Medicaid recipients are enrolled in managed care plans. The managed health plans are responsible for administering the benefit for their Medicaid members. The remaining recipients live in rural areas not served by managed care plans and receive their health care through Medicaid's fee-for-service coverage.

The WTPCP has a goal of increasing utilization of the Medicaid tobacco dependence treatment from less than 2% to 3% by 2014. To help increase utilization, UW-CTRI's Cessation Outreach Program disseminates Medicaid benefit information to providers throughout the state. In 2006, UW-CTRI also launched a communications campaign, "You Can Afford to Quit" to inform Medicaid providers and recipients about what their benefits are, how they can be accessed, how it should be coded and billed for reimbursement (See next page).

³⁸The American Stop Smoking Intervention Study was a six year effort to reduce the smoking rate in 17 U.S. states. ASSIST was funded with approximately \$114 million from the early to mid 1990's by the American Cancer Society and the National Cancer Institute. The goal of the project was to alter the social, cultural, environmental, and economic factors that promote smoking through four policy strategies: promoting smoke-free environments, countering tobacco advertising and promotion, limiting youth's access to tobacco products; and raising excise taxes to increase the price of tobacco products.

³⁹ <http://www.dhs.wisconsin.gov/tobacco/>

⁴⁰ <http://www.ctri.wisc.edu/>

ROLE OF TOBACCO CONTROL

The WTPCP, through UW-CTRI, provides state leadership in tobacco cessation for the Medicaid program and other medical and health systems and organizations. The goals for increasing Medicaid benefit utilization and the outreach to Medicaid recipients have been designed and initiated by UW-CTRI in collaboration with the Medicaid program and WTPCP. When UW-CTRI was funded to provide tobacco cessation leadership, representatives initiated contact with the Medicaid program to provide information and to offering resources to help make the job of providing tobacco dependence treatment to the Medicaid population easier. The Medicaid program responded to the availability of these new resources and has been an active collaborator on several initiatives. In the recent “You Can Afford to Quit” campaign, UW-CTRI and the Medicaid program collaborated on message development and testing, development and approval of fact sheets and other information on the benefit, and facilitating dissemination through multiple UW-CTRI and Medicaid channels (see next page). The Medicaid program also helped fund the campaign by printing large quantities of promotional materials.

Discussions are underway with Medicaid regarding a potential pay for performance plan, ways to increase consumer demand for cessation services, and ways to collaborate more closely to coordinate tobacco dependence treatment, in particular Quit Line services. In addition there is an effort at increasing federal match for cessation medications and services. While some momentum was lost during the 2008 redesign of the Medicaid program, the collaboration is now regaining momentum. During the recent Medicaid program redesign, UW-CTRI continued to provide expertise, helping to sustain the focus on tobacco, and has subsequently reinitiated the collaboration as the changes were completed. An example of this is Medicaid creating a Tobacco Cessation Work Group, with UW-CTRI as well as WTPCP representation.

IMPLEMENTATION AND PROMOTION “CESSATION OUTREACH PROGRAM”

Much of the implementation of the partnership between UW-CTRI and the Medicaid program happens through UW-CTRI’s. The purpose of the outreach program is to increase the rate clinicians provide evidence-based cessation treatment. Six UW-CTRI Regional Outreach Specialists, based in five Wisconsin regions, provide training and technical assistance on interventions and system changes necessary to ensure routine tobacco dependence treatment at clinic visits. Through academic detailing and other methods, the Outreach Specialists serve clinics, hospitals, health systems, insurers and purchasers by disseminating evidence-based treatment recommendations and include information about Medicaid benefits and access. The Outreach Program also links clinicians, organizations and their communities to the Wisconsin Tobacco Quit Line (WTQL), via the “Fax to Quit” program.

Fax to Quit proactively links smokers ready to quit with the trained coaches at the Wisconsin Tobacco Quit Line via a fax referral. For more information see: http://www.ctri.wisc.edu/HC.Providers/healthcare_QL_Fax2Quit.htm.

Benefit Promotion

A media campaign “You Can Afford to Quit”⁴¹ was launched in 2006. The campaign was developed to address the following issues:

- Adult smoking among Medicaid recipients is 50% higher than the adult population as a whole.
- Few Medicaid recipients use the benefit (less than 2% in 2001).
- Medicaid recipients are often not aware of treatments and coverage available to them.
- Wisconsin provides a comprehensive benefit and outreach to providers, but many clinicians and even large health plans are unclear about benefits.

⁴¹ http://www.ctri.wisc.edu/HC.Providers/healthcare_medicaid.htm

The goals of the campaign were to:

- Increase awareness and dispel myths among selected healthcare providers, healthcare personnel and professional health organizations/associations about Medicaid coverage
- Increase consumer demand and increase use of treatment by Medicaid enrollees.
- Develop a more productive relationship with Wisconsin Medicaid and contracted HMO's.

“You Can Afford to Quit” Campaign

Development: Gathered information, identified target audiences, interviewed key informants, collaborated on messages and materials development. Settled on message: You Can Afford to Quit: Medicaid Covers It.

Message testing: Tested messages and approach with stakeholders, insurers, clinicians, administrative staff, Medicaid recipients, Spanish speakers.

Materials development

- In Briefs: Individual, targeted pieces for healthcare providers, pharmacists, mental health and substance abuse counselors and staff (purpose: to dispel myths, provide factual information).
- Laminated reminder sheet for healthcare providers.
- PowerPoint slides (sets for primary and mental health/substance abuse counselors).
- Articles for newsletters.
- Brochures and posters in English and Spanish.

Distribution via: UW-CTRI Outreach Specialists, teleconferences, training events, conferences, ongoing local training and technical assistance, dissemination through health plans and insurers, to tobacco control partners and coalitions, through professional organizations, and through Medicaid enrollment specialists.

EVALUATION AND QUALITY IMPROVEMENT

The “You Can Afford to Quit” campaign is now being formally evaluated. Measures include Medicaid claims data, calls to the Wisconsin Tobacco Quit Line, and distribution of materials through health plans and other partners.

Preliminary results show that:

- Pharmacy claims for smoking cessation medications increased both for health plan and fee-for-service enrollees during the campaign with significantly greater claims among health plan enrollees (the target of the campaign).
- Quitline counseling for Medicaid enrollees increased by 33%.
- Overall tobacco dependence treatment benefit use among enrollees doubled (from 2% to 4%).

UW-CTRI continually monitors progress toward its goal of increasing the number of callers to the Wisconsin Tobacco Quit Line. Although there is limited funding for paid, targeted, advertising, this always boosts the percentage of Medicaid callers.

Key measures:

- Reach of quitline promotion
In 2007, more Wisconsin residents reported that they had heard of the QuitLine (53%) compared to 2005 (40%).
- Provider assistance (BRFSS 2005)
Did your provider discuss quitting methods? – 27.75%
Did your provider discuss use of medications? – 39%

- Rate of serious quit attempts by smokers (BRFSS 2007)
The rate of quit attempts increased from 49.34% (2003) to 58% (2007) while the national rate stayed at less than 50%.
- Clinician referrals to quit line (WTQL data)
Clinicians referrals nearly doubled from 2002 (1086) to 2007 (1902). About 20% of callers are referred by clinicians.
- Utilization of WTQL by populations with tobacco related disparities
In 2007, 15.5% of callers to the WTQL were Medicaid recipients. At the same time they were 11.9% of the population.

Another important source of quality improvement data comes from the Regional Outreach Specialists themselves. As the information campaign rolled out, the Specialists were faced with a series of questions raised by patients and providers who encountered a variety of misinformation from the health plans, from pharmacists filling or denying prescriptions. There were also issues related to some providers who provided incorrect advice to their patients. By forwarding these questions to UW-CTRI, to the Medicaid office, and to the respective health plans, the quality of the information was improved and better access to the benefits was possible.

LESSONS LEARNED

- Top down and bottom up strategies together create synergy
- Stay focused on mission, goals and achieving outcomes while building and nurturing relationships
- The ability to seek, act quickly and build on opportunities is important, especially as policy change occurs
- Champions (or early adopters of change) are invaluable in getting things started, but systems change is necessary in order to achieve sustainability
- Training is continual (e.g.: turn-over) although training needs change over time. Academic detailing needs to involve the entire healthcare team (including medical assistants, administrators, quality improvement professionals, etc.) to develop solutions that work in each unique setting/system

CONTRIBUTORS

Lezli Redmond, MPH

Director for Education & Outreach Programs

University of Wisconsin Medical School, Center for Tobacco Research and Intervention

Rob Adsit, MEd

Education and Outreach Programs Manager

University of Wisconsin Medical School Center for Tobacco Research and Intervention

Vicki Stauffer, BA

Section Chief

Wisconsin Tobacco Prevention and Control Program

Bureau of Community Health

Division of Public Health

Bruce Christiansen, PhD

Lead Researcher

University of Wisconsin Medical School Center for Tobacco Research and Intervention

MEDICAID RESOURCES

MMWR State Medicaid Coverage for Tobacco-Dependence Treatments—United States, 2006 Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a2.htm>

State Tobacco Cessation Coverage Database. The database contains information on Medicaid coverage, state employee health plan coverage, insurance mandates for cessation, quitlines, and ALA programs for each state. These data include details of coverage, like barriers to accessing treatment, as well as the sources for each data point. Available at: <http://lungusa2.org/cessation2/>.

Guide to Community Preventive Services: Tobacco Use Prevention and Control. Contains the U.S. Preventive Services Task Force (USPSTF) recommendations on the use of screening, counseling, and other preventive services that are typically delivered in primary care settings. The USPSTF, an independent panel of experts supported by the Agency for Healthcare Research and Quality (AHRQ), makes recommendations based on systematic reviews of the evidence related to the benefits and potential harms of clinical preventive services. Available at: <http://www.thecommunityguide.org/tobacco/index.html>

Helping Smokers Quit: State Cessation Coverage (2008). A State Policy Trend Report from the American Lung Association. Available at: http://www.lungnet.org/site_files/Helping_Smokers_Quit_State_Cessation_Coverage_11-13-08.pdf

State Medicaid Coverage of Tobacco Cessation Services for Pregnant Women Factsheet (March 20, 2008). A fact sheet from the Campaign for Tobacco-Free Kids. Available at: <http://www.tobaccofreekids.org/research/factsheets/pdf/0289.pdf>.

NAQC's 2006 Medicaid Information Survey (March 2007). The NAQC 2006 Medicaid Information Survey was fielded in September of 2006, to document the scope of efforts undertaken by U.S. quitline administrators with state Medicaid agencies. Available at: <http://smokingcessationleadership.ucsf.edu/Downloads/FS2006Medicaid.pdf>

Working with Medicaid: What Quitlines Have Learned (2007). Background materials and information assembled by the North American Quitline Consortium for the conference call series held in 2007, "Establishing Best Practices for Quitline Operations: Back to Basics". Available at: http://www.tcln.org/cessation/pdfs/NAQC_WhatQuitlinesLearned-2007.pdf

Saving Lives, Saving Money II: Tobacco-Free States Spend Less on Medicaid (2007). A report from the American Legacy Foundation shows the positive impact effective smoking cessation programs can have on state Medicaid expenditures. Available at: http://www.americanlegacy.org/PDFPublications/saving_lives_saving_money.pdf

Promoting Medicaid Benefits (January 2007). Summary of the TCLN roundtable discussion. Available at: http://www.virtualsql.com/abcqxyz/dev/TCLN/resources/pdfs/Promoting_Medicaid_Benefits.pdf

Toolkit: Invest In A Healthy State: Covering Tobacco Cessation Services Under Medicaid. The Center for Tobacco Cessation, in partnership with the National Partnership to Help Pregnant Smokers Quit, has developed a Medicaid and smoking cessation information packet. Available at: http://www.tcln.org/cessation/pdfs/CTCMedicaid_Toolkit.pdf.

Sample Purchasing Specifications Related to Tobacco-Use Prevalence and Cessation (October 2002). Prepared by the George Washington University Center for Health Services Research and Policy in conjunction with officials from the Centers for Disease Control and Prevention. Available at: <http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/tobacco/smokingspecs.pdf>

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Halpin HA, Bellows NM and McMenamin SB. Update State Report: Medicaid Coverage of Tobacco Dependence Treatments. *Health Affairs*, March/April 2006; 25(2): 550-556.

Miller LS, Zhang X, Novotny T; et al. State estimates of Medicaid expenditures attributable to cigarette smoking, fiscal year 1993. *Public Health Rep.* 1998;113(2):140-151.

Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med.* 2006;31(1):52-61.

Petersen, R, et. al. Medicaid reimbursement for prenatal smoking intervention influences quitting and cessation. *Tob Control* 2006;15(1):30-4. Available at: <http://tobaccocontrol.bmj.com/cgi/content/abstract/15/1/30>

STATE SPECIFIC TOOLS

Benefit charts and fact sheets

New York fact sheet, "Medicaid Coverage For Stop Smoking Medications - Health Provider". Available at: <http://www.nysmokefree.com/newweb/FactSheets/MEDICAID%20Provider%20ENG.pdf>

New York fact sheet, “Medicaid Coverage For Stop Smoking Medications – Recipient” .Available at: <http://www.nysmokefree.com/newweb/FactSheets/MEDICAID%20Recipient%20ENG.pdf>

New York NYS Medicaid Smoking Cessation Coverage Highlights available at: <http://www.nysmokefree.com/newweb/PageView.aspx?p=5510>

Utah benefit matrix: “Tobacco Cessation Benefits for Medicaid and Primary Care Network Patients” matrix. Available at: <http://www.tobaccofreeutah.org/medpcnbenefits.pdf>

Wisconsin Medicaid Fact Sheet: “Tobacco Cessation Products and Services Covered Under BadgerCare Plus and Wisconsin Medicaid.” Available at: <http://www.ctri.wisc.edu/News.Center/Fact%20Sheets/Updated%20ROS%20Handouts/Badgercare.plus.update.pdf>

Wisconsin Medicaid Fact Sheet: “Wisconsin Medicaid, BadgerCare & SeniorCare Cover Treatments to Quit Tobacco”. Available at: <http://www.ctri.wisc.edu/News.Center/Fact%20Sheets/Updated%20ROS%20Handouts/3.Medicaid%20Facts.pdf>

Wisconsin. UW-CTRI’s webpage, Medicaid Covers Quit-Smoking Treatment, contains fact sheets and other materials to promote Medicaid coverage for tobacco treatments and to assist Wisconsin providers help qualifying beneficiaries to quit. Available at: http://www.ctri.wisc.edu/HC.Providers/healthcare_medicaid.htm

Medicaid promotion

Oklahoma, “Help is Here” campaign. A promotional brochure for patients is available at: <http://www.ohca.state.ok.us/publications/pdflib/SFLENG%E2%80%93NOSMOK.pdf>

Oregon’s, “Help is Here” campaign. A promotional brochure for patients. Brochures are available in English, Spanish, Russian and Vietnamese. Available at: <http://www.tcln.org/cessation/medicare.html>

Utah “Do You Want to Quit” 2009 quitline promotional mailer in English and Spanish. Available at: <http://www.tcln.org/cessation/medicare.html>

Wisconsin “You Can Afford to Quit Smoking” campaign. Promotional brochure for patients available at: <http://www.ctri.wisc.edu/HC.Providers/Medicaid/englishbrochure.pdf>

Wisconsin “You Can Afford to Quit Smoking” campaign presentation for TCLN Roundtable conference call. Available at: www.tcln.org/schedule/docs/01.16.07/Wisconsin.pdf

WEBSITES

Centers for Medicare & Medicaid Services: <http://www.cms.hhs.gov/>. The Centers for Medicare & Medicaid Services (Department of Health and Human Services) website provides information about Medicaid.

The Kaiser Family Foundation’s Commission on Medicaid and the Uninsured: <http://www.kff.org/about/kcmu.cfm>
Provides Medicaid fact sheets and tools and permits customizing state Medicaid fact sheets. Includes a Medicaid benefits data base.

North American Quitline Consortium (NAQC): <http://www.naquitline.org>. The NAQC website provides information about quitline services available in all 50 states, the District of Columbia, Canada, and Mexico.

ClearWay MinnesotaSM: <http://www.clearwaymn.org/>

New York Tobacco Control Program (NYTCP): http://www.health.state.ny.us/prevention/tobacco_control/.

New York Medicaid Program: http://www.health.state.ny.us/health_care/medicaid/

Oklahoma State Department of Health and the Tobacco Settlement Endowment Trust Fund (TSETF): <http://www.ok.gov/tset/>

Oklahoma Tobacco Use Prevention Service (TUPS): <http://www.health.state.ok.us/program/tobac/>

Oregon Division of Medical Assistance Programs (DMAP): <http://www.oregon.gov/DHS/healthplan/>

Oregon Tobacco Prevention and Education Program (TPEP): <http://www.oregon.gov/DHS/ph/tobacco/>

Utah Medicaid Program: <http://health.utah.gov/medicaid/>

Utah Tobacco Prevention and Control Program (TPCP): <http://www.tobaccofreeutah.org/>

University of Wisconsin Center for Tobacco Research and Intervention (UW-CTRI): <http://www.ctri.wisc.edu/>

Wisconsin Tobacco Prevention and Control Program (WTPCP): <http://www.dhs.wisconsin.gov/tobacco/>

A PROJECT OF THE TOBACCO CESSATION LEADERSHIP NETWORK

Compiled and edited by: Wendy Bjornson, MPH
Director, Tobacco Cessation Leadership Network
Oregon Health and Science University, Portland, Oregon

Assistance and Coordination by: Elizabeth White, MPA
Research Associate, Project Coordinator, Tobacco Cessation Leadership Network
Oregon Health and Science University, Portland, Oregon.

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Tobacco Cessation
Leadership Network

c/o Smoking Cessation Center • Oregon Health & Science University
3181 SW Sam Jackson Park Rd. CR 115 • Portland, Oregon 97239
www.tcln.org